IPDR6702 NORTH CAROLINA PAGE: 1

RUN DATE: 01/15/2006 IPRS CHECKWRITE SUMMARY REPORT

CHECKWRITE DATE: 01/18/2006

FINANCIAL PAYER: NCDMH

PROVIDER NUMBER	PROVIDER NAME	HIGH DENIAL EOBS	NUMBER OF DENIALS	DESCRIPTION	TNC DENIALS	TOTAL DENIALS	TOTAL CLAIMS FINALIZED	TOTAL CLAIMS PAID
3404901	SMOKY MOUNTAINM	8505	2	CLAIM DENIED DUE TO INSUFFICIE				
	H/DD/SAS			NT BUDGET				
		0	0		0	2	2	0
3404904	WESTERN HIGHLAN	191	50	CLIENT ID NUMBER DOES NOT MATC				
	DS LME			H PATIENT NAME				
		11	31	CLIENT NOT ELIGIBLE ON SERVICE	0	119	11878	11759
				DATE				
		8537	25	PROCEDURE IS NOT PAYABLE FOR Y				
				OUR PROVIDER TYPE AND				
				SPECIALTY IN ACCORDANCE TO MEN				
3404910	PATHWAYS	8505	337	CLAIM DENIED DUE TO INSUFFICIE				
				NT BUDGET				
		79	203	THIS SERVICE IS NOT PAYABLE TO	5	1138	7792	6652
				YOUR SUBMITTED BILLING				
				PROVIDER TYPE AND SPECIALTY IN				
		8534	199	SERVICE FACILITY LOCATION IS N				
				OT A VALID IPRS ATTENDING				
				PROVIDER. PLEASE VERIFY THE F				
3404912	CATAWBA COUNTYM	8931	136	AMTNC INELIGIBLE TO RECEIVE SE				
	ENTAL HEALT			RVICES IN IPRS.				
		11	18	CLIENT NOT ELIGIBLE ON SERVICE	138	183	1301	1118
				DATE				
		8599	13	DETAIL NOT COVERED BY COMBINAT				
				ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
3404913	MECKLENBURG COM	8599	76	DETAIL NOT COVERED BY COMBINAT				
	ENTAL HEALT			ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		11	23	CLIENT NOT ELIGIBLE ON SERVICE	17	116	309	193
				DATE				
		8932	12	CMTNC INELIGIBLE TO RECEIVE SE				
				RVICES IN IPRS.				
3404916	CROSSROADS BEHA	21	1144	DUPLICATE OF CLAIM-SYSTEM				
	VIORAL HEAL							
		8599	28	DETAIL NOT COVERED BY COMBINAT	0	1174	1202	28
				ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		191	2	CLIENT ID NUMBER DOES NOT MATC				
				H PATIENT NAME				
3404917	CENTERPOINT HUM	8518	296	CLAIM DENIED, SUBMITTED BEYOND				
	AN SERVICES			FILING TIMELIMIT. PRIOR				
				FISCAL YEAR DOS (JULY 1 - JUNE				
		21	114	DUPLICATE OF CLAIM-SYSTEM	37	450	521	71
		8931	36	AMTNC INELIGIBLE TO RECEIVE SE				
				RVICES IN IPRS.				

PROVIDER NUMBER	PROVIDER NAME	HIGH DENIAL EOBS	NUMBER OF DENIALS	DESCRIPTION	TNC DENIALS	TOTAL DENIALS	TOTAL CLAIMS FINALIZED	TOTAL CLAIMS PAID
3404918	ROCKINGHAM CO M ENTAL HEALT	0	0	*** NO DATA TO REPORT ***				
		0	0		0	0	0	0
3404919	GUILFORD CO MEN TAL HEALTHC	21	1155	DUPLICATE OF CLAIM-SYSTEM				
		8535	260	SERVICE FACILITY LOCATION WAS NOT INCLUDED IN YOUR 837. PLEASE RESUBMIT YOUR CLAIM WIT	42	1615	11875	10260
		8599	61	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.				
3404920	ALAMANCE CASWEL L AREA MH D	21	322	DUPLICATE OF CLAIM-SYSTEM				
		8599	216	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.	32	930	2935	2005
		11	184	CLIENT NOT ELIGIBLE ON SERVICE DATE				
3404921	ORANGE PERSON C HATHAM AREA	21	238	DUPLICATE OF CLAIM-SYSTEM				
		5312	159	PRIOR AUTHORIZED DOLLARS EXCEE DED	8	1014	11413	10399
		8535	142	SERVICE FACILITY LOCATION WAS NOT INCLUDED IN YOUR 837. PLEASE RESUBMIT YOUR CLAIM WIT				
3404922	THE DURHAM CENT ER	8535	438	SERVICE FACILITY LOCATION WAS NOT INCLUDED IN YOUR 837. PLEASE RESUBMIT YOUR CLAIM WIT				
		21	207	DUPLICATE OF CLAIM-SYSTEM	0	938	2304	1366
		11	143	CLIENT NOT ELIGIBLE ON SERVICE DATE				
3404923	FIVE COUNTY MH	11	291	CLIENT NOT ELIGIBLE ON SERVICE DATE				
		21	218	DUPLICATE OF CLAIM-SYSTEM	0	853	2384	1531
		8000	115	NO RATE AVAILABLE ON FILE TO P RICE THIS CLAIM DETAIL				
3404925	SANDHILLS CENTE R FOR MH/DD	21	382	DUPLICATE OF CLAIM-SYSTEM				
		8599	309	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.	46	1527	8569	7042
		8518	192	CLAIM DENIED, SUBMITTED BEYOND FILING TIMELIMIT. PRIOR FISCAL YEAR DOS (JULY 1 - JUNE				
3404926	SOUTHEASTERN RE G MENTAL HL	8535	266	SERVICE FACILITY LOCATION WAS NOT INCLUDED IN YOUR 837. PLEASE RESUBMIT YOUR CLAIM WIT				
		8599	198	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.	0	534	4301	3767
		21	39	DUPLICATE OF CLAIM-SYSTEM				

PROVIDER NUMBER	PROVIDER NAME	HIGH DENIAL EOBS	NUMBER OF DENIALS	DESCRIPTION	TNC DENIALS	TOTAL DENIALS	TOTAL CLAIMS FINALIZED	TOTAL CLAIMS PAID
3404927	CUMBERLAND CO M	8505	478	CLAIM DENIED DUE TO INSUFFICIE				
	HC			NT BUDGET				
		21	86	DUPLICATE OF CLAIM-SYSTEM	0	771	3387	2616
		8535	84	SERVICE FACILITY LOCATION WAS				
				NOT INCLUDED IN YOUR 837.				
				PLEASE RESUBMIT YOUR CLAIM WIT				
3404929	LEE HARNETT MH/	0	0	*** NO DATA TO REPORT ***				
	DD/SAS							
		0	0		0	0	0	0
3404930	JOHNSTON COUNTY	8518	97	CLAIM DENIED, SUBMITTED BEYOND				
	MNTL HLTHC			FILING TIMELIMIT. PRIOR				
				FISCAL YEAR DOS (JULY 1 - JUNE				
		8599	58	DETAIL NOT COVERED BY COMBINAT	67	297	2519	2222
				ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		8931	44	AMTNC INELIGIBLE TO RECEIVE SE				
				RVICES IN IPRS.				
3404931	WAKE CO HUM SVC	11	220	CLIENT NOT ELIGIBLE ON SERVICE				
	BILLING OF			DATE				
		21	194	DUPLICATE OF CLAIM-SYSTEM	25	604	4411	3807
		8599	76	DETAIL NOT COVERED BY COMBINAT				
				ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
3404933	SOUTHEASTERN CT	21	172	DUPLICATE OF CLAIM-SYSTEM				
	R FOR MH/DD							
		8599	154	DETAIL NOT COVERED BY COMBINAT	16	487	2051	1564
				ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		8535	56	SERVICE FACILITY LOCATION WAS				
				NOT INCLUDED IN YOUR 837.				
				PLEASE RESUBMIT YOUR CLAIM WIT				
3404934	ONSLOW CARTERET	11	158	CLIENT NOT ELIGIBLE ON SERVICE				
	BEHAV HEAL			DATE				
		21	36	DUPLICATE OF CLAIM-SYSTEM	0	218	233	15
		8535	24	SERVICE FACILITY LOCATION WAS				
				NOT INCLUDED IN YOUR 837.				
				PLEASE RESUBMIT YOUR CLAIM WIT				
3404935	WAYNE CO MENTAL	0	0	*** NO DATA TO REPORT ***				
	HEALTH CTR							
		0	0		0	0	0	0
3404936	WILSON-GREENE M	21	57	DUPLICATE OF CLAIM-SYSTEM				
	ENTAL HEALT							
		79	34	THIS SERVICE IS NOT PAYABLE TO	14	116	3550	3434
				YOUR SUBMITTED BILLING				
				PROVIDER TYPE AND SPECIALTY IN				
		8932	7	CMTNC INELIGIBLE TO RECEIVE SE				
				RVICES IN IPRS.				

PROVIDER NUMBER	PROVIDER NAME	HIGH DENIAL EOBS	NUMBER OF DENIALS	DESCRIPTION	TNC DENIALS	TOTAL DENIALS	TOTAL CLAIMS FINALIZED	TOTAL CLAIMS PAID
3404937	EDGECOMBE NASH	8518	395	CLAIM DENIED, SUBMITTED BEYOND				
	MNTL HLTH C			FILING TIMELIMIT. PRIOR				
				FISCAL YEAR DOS (JULY 1 - JUNE				
		21	79	DUPLICATE OF CLAIM-SYSTEM	1	538	807	269
		79	59	THIS SERVICE IS NOT PAYABLE TO				
				YOUR SUBMITTED BILLING				
				PROVIDER TYPE AND SPECIALTY IN				
3404938	VGFW DBA RIVERS	0	0	*** NO DATA TO REPORT ***				
	TONE COUNSE							
		0	0		0	0	0	0
3404939	NEUSE MENTAL HE	8599	25	DETAIL NOT COVERED BY COMBINAT				
	ALTH CENTER			ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		11	15	CLIENT NOT ELIGIBLE ON SERVICE	0	60	1137	1077
				DATE				
		8535	7	SERVICE FACILITY LOCATION WAS				
				NOT INCLUDED IN YOUR 837.				
				PLEASE RESUBMIT YOUR CLAIM WIT				
3404941	PITT CO MH/DD/S	27	373	DIAGNOSIS CODE MISSING OR INVA				
	AS CENTER			LID. VERIFY AND ENTER THE				
				CORRECT DIAGNOSIS CODE AND SUB				
		191	57	CLIENT ID NUMBER DOES NOT MATC	0	499	1872	1373
				H PATIENT NAME				
		8599	57	DETAIL NOT COVERED BY COMBINAT				
				ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
3404942	ROANOKE CHOWANH	21	111	DUPLICATE OF CLAIM-SYSTEM				
	UMAN SERVIC							
		8599	62	DETAIL NOT COVERED BY COMBINAT	17	234	2919	2685
				ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		8535	36	SERVICE FACILITY LOCATION WAS				
				NOT INCLUDED IN YOUR 837.				
				PLEASE RESUBMIT YOUR CLAIM WIT				
3404943	ALBEMARLE MENTA	21	160	DUPLICATE OF CLAIM-SYSTEM				
	L HEALTH CE							
		8535	82	SERVICE FACILITY LOCATION WAS	45	419	1403	984
				NOT INCLUDED IN YOUR 837.				
				PLEASE RESUBMIT YOUR CLAIM WIT				
		79	59	THIS SERVICE IS NOT PAYABLE TO				
				YOUR SUBMITTED BILLING				
				PROVIDER TYPE AND SPECIALTY IN				
3404944	EASTPOINTE HUMA	8535	279	SERVICE FACILITY LOCATION WAS				
	N SERVICES			NOT INCLUDED IN YOUR 837.				
				PLEASE RESUBMIT YOUR CLAIM WIT				
		8599	175	DETAIL NOT COVERED BY COMBINAT	1	581	2296	1715
				ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		21	103	DUPLICATE OF CLAIM-SYSTEM				
3404946	FOOTHILLS AREAM	21	5103	DUPLICATE OF CLAIM-SYSTEM				
	ENTAL HEALT							
		8599	278	DETAIL NOT COVERED BY COMBINAT	0	5491	11197	5706
				ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		8950	110	CLIENT ONLY ENROLLED IN TRACKI				
				NG POP GROUP. MUST ALSO BE				
				ENROLLED IN A FUNDED POP GROUP				

PROVIDER NUMBER	PROVIDER NAME	HIGH DENIAL EOBS	NUMBER OF DENIALS	DESCRIPTION	TNC DENIALS	TOTAL DENIALS	TOTAL CLAIMS FINALIZED	TOTAL CLAIMS PAID
3404957	TIDELAND MENTAL HEALTH CTR	21	342	DUPLICATE OF CLAIM-SYSTEM				
		191	50	CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME	3	410	758	348
		8599	6	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.				
3404979	NEW RIVER AREAM H/DD/SA PRO	8535	643	SERVICE FACILITY LOCATION WAS NOT INCLUDED IN YOUR 837. PLEASE RESUBMIT YOUR CLAIM WIT				
		21	509	DUPLICATE OF CLAIM-SYSTEM	52	1390	5365	3975
		8599	75	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.				